October 2005 Annual Enrollment Edition - Not Available After January 1, 2006

The Insurance Advantage

South Carolina Budget and Control Board — Employee Insurance Program

Welcome

Welcome to the 2005 issue of *The Insurance Advantage*. This newsletter will update you on your insurance coverage options for 2006 and guide you through the open enrollment process.

The Insurance Advantage will be useful to you throughout the open enrollment period, October 1-31, 2005. In January, you will receive the 2006 *Insurance Benefits Guide*, which will be your primary source for comprehensive information on all of the benefits programs offered through EIP.

Remember, all changes you make during open enrollment will be effective January 1, 2006.

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Don't Let This Special, Open Enrollment for Supplemental Long Term Disability Insurance Pass You By

What would you do if you were suddenly unable to work due to illness or disability? Would you be able to meet your financial obligations?

Consider Supplemental Long Term Disability (SLTD) insurance from Standard Insurance Company. You can protect more of your income with SLTD insurance. With SLTD, you can:

- Protect more of your predisability earnings than with the Basic Long Term Disability insurance that is provided at no charge.
- Pay your premiums through convenient payroll deductions, with new, ***lower*** *rates that went into effect September 1, 2005.*
- Choose a benefit waiting period of 90 days or 180 days (the length of time before benefits begin), whichever best suits your needs.

Enroll Now!

During the October 2005 open enrollment period, all you have to do to get SLTD coverage is select it on your Notice of Election (NOE) form. Your coverage will become effective January 1, 2006.

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General Assembly Provides Additional Funding for 2006

During this past legislative session, the South Carolina General Assembly approved additional funding for the health insurance plans offered by the Employee Insurance Program (EIP). As a result, the Fiscal Year 2005-06 Appropriations Act increased employer contributions toward health insurance an average of 4.8 percent.

This funding will allow premiums for the State Health Plan to remain the same for the 2006 plan year. Premiums for CIGNA, BlueChoice HealthPlan (previously known as *Companion*) and MUSC Options will increase. Premiums for the TRICARE Supplement Plan will not increase for the 2006 plan year.

Subscribers of Optional Employer Groups That Are Experience-Rated

Although the General Assembly appropriated additional funding for next year, premiums for subscribers of experience-rated groups (such as cities, counties, and other local subdivisions) may increase, decrease, or remain the same, based on the group's rating. **If you are a subscriber of an experience-rated group, your benefits office will announce next year's rates.**

Premiums for all plans and subscriber categories (except for groups that are experience rated) can be found on pages 10-11.

October Enrollment is the Time to Make Changes

If you would like to change your insurance coverage, October 1-31 is the time to do it. During **open enrollment**, which occurs in odd-numbered years, you have more options than you do during annual enrollment. Any changes you make will be effective January 1, 2006.

Health

The chart on page 14 is a brief comparison of the different health insurance plans offered through the Employee Insurance Program (EIP). The premiums are on pages 10-11. For details, read the 2005 *Insurance Benefits Guide* (IBG). The chapter on the State Health Plan, which includes the Savings Plan and the Standard Plan, begins on page 5. The health maintenance organizations (HMOs) are discussed beginning on page 53. Remember that BlueChoice HealthPlan of South Carolina was formerly Companion HMO and is referred to as Companion in the IBG. If you have specific questions about any of the plans, contact information is on page 15 of this newsletter.

If you are satisfied with your health plan, you do not need to do anything. You will be automatically re-enrolled for 2006.

Active Employees and COBRA Subscribers: In October, you and your eligible dependents may enroll in, or change to, these health plans:

- The State Health Plan Savings Plan (non-Medicare enrolled employees)
- The State Health Plan Standard Plan
- An HMO offered in the county where you live or work
- If you are eligible, you may enroll in the **TRICARE Supplement**, which is secondary coverage to the U.S. Department of Defense's healthcare program for the military.

If you are a survivor who is eligible for Medicare, or a retiree, refer to page 4 for your choices.

If you are eligible for health insurance coverage through EIP, but have not enrolled, you may enroll yourself and your eligible dependents during open enrollment. You will, however, be subject to an 18-month pre-existing condition period, unless you enroll within 31 days of a special eligibility situation, such as marriage; birth, adoption or placement; or involuntary loss of other coverage. If you have a certificate of prior coverage showing no more than a 62-day break in coverage, the pre-existing period may be reduced.

You may drop health coverage for yourself or for your dependents.

Dental

- You may enroll in or drop State Dental Plan coverage for yourself and/or your eligible dependents. If you drop the State Dental Plan and are enrolled in Dental Plus, your Dental Plus coverage will be dropped too. Once you enroll in Dental or Dental Plus coverage, you are locked into that coverage for two years, until the next open enrollment period (October 2007).
- You may enroll in or drop Dental Plus for yourself and/or your eligible dependents. To participate in Dental Plus, you must be enrolled in the State Dental Plan and cover the same family members under both plans.

New COBRA Procedures for 2006

Beginning January 1, 2006, the Employee Insurance Program will begin enforcing the 60-day COBRA notification deadline. Ineligible dependent spouses and children, who have a COBRA-qualifying event and who wish to continue coverage through COBRA, must notify their benefits administrator within 60 days of the actual date of ineligibility or within 60 days of the date coverage would have been lost, had the ineligibility been reported in a timely manner, whichever is later. If notification is not made within 60 days of the date of ineligibility, COBRA continuation will not be offered.

Optional and Dependent Life

- For information about coverage changes you, as an active employee, may make for yourself and your spouse, see the article on page 7.
- Eligible children of active employees can be enrolled throughout the year without providing medical evidence of good health.
- Remember, you must work one day in the new year before your coverage will become effective.

Supplemental Long Term Disability

- Active employees may enroll in, or make changes to, Supplemental Long Term Disability Insurance without providing medical evidence of good health. See page 1 for details.

Long Term Care

- **With approved medical evidence of good health**, active employees, retirees and survivors may enroll themselves, their spouses, their parents or their parents-in-law during open enrollment and throughout the year.

MoneyPlu$

To participate in a Medical Spending Account, you must be an active employee and, by January 1, 2006, you must have worked for one year, for an employer participating in EIP programs.

- You must enroll or re-enroll in a Dependent Care Account and/or a Medical Spending Account or a limited-use Medical Spending Account if you wish to participate in 2006.
- Medical Spending Account subscribers may sign up for an EZ REIMBURSE® MasterCard®, for which there is an additional fee. The EZ REIMBURSE® MasterCard® is not available to employees who participate in a limited-use Medical Spending Account.

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October Enrollment

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- If you enroll in the Savings Plan during October, your enrollment will be effective January 1, 2006. As of that date, you will be eligible to open a Health Savings Account (HSA), provided you are not covered by other health insurance (including Medicare), unless that health insurance is also a high deductible health plan, and you cannot be claimed as a dependent on another person's income tax return.

If you have an HSA, you are no longer eligible for a Medical Spending Account. However, you are eligible for a limited-use Medical Spending Account. For more information, refer to the *MoneyPlu$ Tax-favored Accounts Guide,* which is available from your benefits administrator.

After your enrollment in the Savings Plan becomes effective, you may enroll in a HSA at any time during the year. If you were enrolled in an HSA in 2005, you do not need to re-enroll in your HSA for 2006. If you were enrolled in an HSA in 2005, and you wish to change the amount of your monthly contributions, just enter the new amount on your MoneyPlu$ enrollment form. You may change the amount you contribute to your HSA monthly. However, the maximum amount you may deposit in the account each year will be based on the number of months you were eligible for the account during the year.

MoneyPlu$ Health Savings Accounts—Additional Investment Options Now Available

If you are enrolled in the State Health Plan Savings Plan and have a Health Savings Account (HSA) with NBSC (an affiliate of Synovus Financial Corp. and trustee for the MoneyPlu$ HSA), additional investment options are now available. If your HSA has a balance of $3,500 or more, you may add an investment option to your account. You will then be able to invest your HSA funds in several Fidelity Investment® mutual funds available through Synovus Securities, Inc.*

When your HSA account balance reaches $3,500, you will receive a letter announcing these new investment options, any related fees and a toll-free number to call to request an enrollment package. The package will include an investment account enrollment form and a fact sheet and prospectus for each available fund.

For more information about the MoneyPlu$ HSA with NBSC, please refer to NBSC's Web site at www.nationalbanksc.com, and choose the Health Savings Account option under "Personal Banking" or call 877-367-4HSA (4472).

Remember:

To change your health plan, or to make any other changes in your coverage, you must complete a Notice of Election form (NOE). The form is available online or from your benefits administrator. To fill out an NOE online, go to the EIP Web site, www.eip.sc.gov, choose your category, then click on "Forms." After you complete the form, give it to your benefits administrator before the close of business on October 31, 2005 (this may not apply to some retirees, survivors and COBRA subscribers).

The registered broker-dealer offering brokerage products for Synovus is Synovus Securities, Inc., member NASD/SIPC. Investment products and services are **not FDIC insured, are **not deposits** of or obligations of any Synovus Financial Corp. (SFC) bank, are **not guaranteed** by any SFC bank and **involve investment risk**, including possible loss of principal amount invested. Your Synovus-owned bank and Synovus Securities, Inc., are part of the Synovus family of companies.*

State Health Plan Offers New Tobacco Treatment Program

Tobacco use has numerous ill-effects on a tobacco user's health, from cancer to heart disease to complications for unborn babies. Additionally, it can be a painfully difficult addiction to break.

In our ongoing attempts to assist our subscribers in pursuing and maintaining a healthy lifestyle, the Employee Insurance Program (EIP) would like to announce an innovative new tobacco treatment program for subscribers and dependents. Starting January 1, 2006, any State Health Plan subscriber or dependent can enroll in this free program.

APS Healthcare will offer services through the Free & Clear® program, one of the most successful tobacco treatment programs available today. Free & Clear® addresses all types of tobacco use: cigarettes, cigars, pipes and smokeless tobacco. Free & Clear® consults with the participant to tailor a personalized quit plan. As part of this plan, the subscriber receives a Quit Kit and weekly telephone consultations with a tobacco treatment specialist. The program also provides the participant with nicotine replacement products (patch, gum or lozenge) and unlimited access to a toll-free support hotline—all without any copayment or out-of-pocket costs. The Free & Clear® program also allows participants to re-enroll in the program if they experience a relapse in the future.

To enroll in Free and Clear®, subscribers can call 866-784-8454 (toll-free). Once eligibility is verified, the caller will then be transferred to a tobacco treatment specialist to begin the program.

Retirees May Make Changes During Open Enrollment

Now is the time to examine your health insurance and decide if the plan in which you are enrolled best suits your needs. If you would like to make changes, you may do so during open enrollment, which occurs October 1-31. The changes you make will become effective January 1, 2006.

If you are satisfied with your coverage, you do not need to do anything. You will be automatically re-enrolled for 2006.

Health Plan Options for Retirees Who Are Not Eligible for Medicare

You and your eligible dependents may enroll in, change to or drop:

- The State Health Plan Savings Plan
- The State Health Plan Standard Plan
- An HMO, including MUSC Options, offered in the county where you live
- If you are eligible, you may enroll in the **TRICARE Supplement**, secondary coverage to the U.S. Department of Defense's healthcare program for the military.

If you are eligible for health insurance coverage through the Employee Insurance Program (EIP), but have not enrolled, you may enroll yourself and your eligible dependents during opening enrollment. You will, however, be subject to the 18-month pre-existing condition limitation, unless you enroll within 31 days of a special eligibility situation, such as marriage; birth, adoption or placement; or involuntary loss of other coverage. If you have a certificate of prior coverage showing no more than a 62-day break in coverage, the pre-existing period may be reduced.

The table on page 14 is a brief comparison of the different health insurance plans offered through EIP, and rates are on page 10-11. For more information, read the 2005 *Insurance Benefits Guide* (IBG). The chapter on the State Health Plan, which includes the Savings Plan and the Standard Plan, begins on page 5. The health maintenance organizations (HMOs) are discussed beginning on page 53. Remember that BlueChoice HealthPlan of South Carolina was formerly Companion HMO and is referred to as Companion in the IBG. If you have specific questions about any of the plans, contact information is on page 15 of this newsletter.

If you enroll in the Savings Plan during October, your enrollment will be effective January 1, 2006. As of that date, you are eligible to open a **Health Savings Account** (HSA), if you are not covered by other health insurance (including Medicare), and cannot be claimed as a dependent on another person's income tax return.

You may change the monthly amount you contribute to your HSA throughout the year. However, the maximum amount you may deposit in the account each year will be based on the number of months you were eligible for the account during the year. You may open an HSA with NBSC (an affiliate of Synovus Financial Corp. and trustee for the MoneyPlu$ HSA) or another HSA trustee. The South Carolina Retirement Systems has arranged with NBSC to allow your HSA contributions to be deducted from your retirement check and forwarded directly to NBSC. If you use a different HSA trustee, you must make your own deposits to your account. Your HSA contributions will be made on an after-tax basis. You may then claim them on your tax return.

New for 2006: Turning 65

When you are covered under retiree group health insurance and turn 65, Medicare becomes your primary health insurance (special considerations may apply for retirees with other active coverage). At that time, you will receive a letter from EIP inviting you to choose the Standard Plan, the Medicare Supplemental Plan or a HMO as your secondary coverage. **If you do not make a choice, you will be assigned to the Medicare Supplemental Plan.** See pages 10-11 for 2006 Medicare Supplemental Plan premiums.

Health Plan Options for Retirees Who Are Eligible for Medicare

You and your eligible dependents may enroll in or change to:

- The State Health Plan Standard Plan
- The Medicare Supplemental Plan
- An HMO offered in the county where you live, including MUSC Options, which is now available to retirees with Medicare

The changes you make during open enrollment will be effective January 1, 2006.

If you are eligible for health insurance coverage with the Employee Insurance Program (EIP), but have not enrolled, you may enroll yourself and your eligible dependents during open enrollment, October 1-31. You will, however, be subject to the 18-month pre-existing condition period, unless you enroll within 31 days of a special eligibility situation, which includes marriage; birth, adoption or placement; or involuntary loss of other coverage. If you have a certificate of prior coverage showing no more than a 62-day break in coverage, the pre-existing period may be reduced.

Remember, if you did not enroll in the Medicare Supplemental Plan

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Retirees May Make Changes During Open Enrollment

Continued from previous page

within 31 days of Medicare eligibility, you can only do so during an open enrollment period, such as October 2005. Your next opportunity will be in October 2007.

The benefits offered by the different health insurance plans vary. To compare the plans, and to determine which one is best for you, refer to the 2005 *Insurance Benefits Guide.*

Information on the Standard Plan in retirement begins on page 182. The section on the Medicare Supplemental Plan starts on page 187. You can learn about how the HMOs work with Medicare by turning to page 193. Remember that BlueChoice HealthPlan of South Carolina was formerly Companion HMO and is referred to as Companion in the IBG.

You can also get more information by contacting the HMOs. Telephone numbers and Web site addresses for each HMO are listed on page 15 of this newsletter. A chart showing which counties each HMO covers is on page 8-9.

Insurance Options for All Retirees

These programs are available to retirees and their eligible dependents, whether or not they are enrolled in Medicare:

Long Term Care

- **With approved medical evidence of good health**, a retiree, a spouse, or a surviving spouse may enroll throughout the year.

Dental

You may enroll in or drop:

- State Dental Plan coverage for yourself and/or your eligible dependents. If you drop State Dental Plan coverage and are enrolled in Dental Plus, your Dental Plus coverage will be dropped too.
- Dental Plus coverage for yourself and/or your eligible dependents. To participate in Dental Plus, you must be enrolled in the State Dental Plan and cover the same family members under both plans.

Remember:

To change coverage, you must complete a Retiree Notice of Election (RNOE) form. This form is available from EIP or from your benefits administrator. You also may complete it online. Go to the EIP Web site, www.eip.sc.gov, choose your category and then select "Forms." After you have completed the RNOE, send it to:

- EIP, if you are retired from a state agency, a school district or an institution of higher education
- Your benefits administrator, if you are retired from an optional employer, such as a city or a county government.
- Return your RNOE form by October 31, 2005.

Important Medicare Reminder:

If you or one of your dependents becomes eligible for Medicare due to age or disability, you must notify EIP within 31 days of Medicare eligibility. **If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance,** when EIP discovers you are eligible for Medicare, EIP will:

- Immediately begin paying benefits as if you were enrolled in Medicare
- Seek reimbursement for overpaid claims going back to the date you or your dependent(s) became eligible for Medicare.

Enroll in Medicare When You Become Eligible

When you or one of your covered dependents becomes eligible for Medicare – whether it is due to age or to disability – you must notify the Employee Insurance Program (EIP) within 31 days of the Medicare-eligibility date.

To make sure you receive the highest level of coverage, EIP recommends you enroll in Medicare Part A (hospital) **and** Part B (medical). Even if you do not, your health insurance with EIP will pay as if you are. Medicare becomes your primary insurance when you become eligible for it. Your EIP-sponsored retiree insurance is your secondary insurance, which means it pays any benefits for which you are eligible after your primary insurance, Medicare, has paid its share of the costs.

After you become eligible for Medicare, your retiree insurance will pay benefits as if you *are* enrolled in Medicare Parts A and B, *even if you are not enrolled.* This means that even if you do not enroll in Medicare, you will be responsible for the part of your healthcare expenses that Medicare would have paid if you had been enrolled in it.

If you do not notify EIP when you or your dependent(s) become eligible for Medicare, your retiree insurance may continue to pay claims as if it were your primary insurance. If this happens and EIP later discovers you were eligible for Medicare when you received the services, EIP will seek reimbursement for any claims that were overpaid because you were not enrolled in Medicare.

To learn how Medicare and your retiree insurance work together to help pay for your healthcare, refer to the 2005 *Insurance Benefits Guide*'s Retiree chapter, beginning on page 174. For details on Medicare's requirements for enrollment, late enrollment, effective dates of coverage and any penalties related to late enrollment, please contact Medicare at 800-633-4227 or visit the Medicare Web site at www.medicare.gov.

Remember: You can only enroll in the Medicare Supplemental Plan within 31 days of eligibility or during open enrollment, which occurs in odd-numbered years. The plan is designed to pay Medicare-approved charges that Medicare does not pay, such as deductibles and coinsurance.

MoneyPlu$ EZ REIMBURSE® MasterCard® Card[1] Reminders

If you are an active subscriber, planning to enroll or re-enroll in a MoneyPlu$ Medical Spending Account (MSA) for 2006, you may also be considering signing up for the EZ REIMBURSE® Card that deducts funds directly from your MSA to pay eligible expenses.[2]

Below are some important reminders for using the EZ REIMBURSE® Card that will help you get the most out of it. For additional information, refer to the MoneyPlu$ *Tax-Favored Accounts Guide* for details about the card and other MoneyPlu$ programs and eligibility. This booklet is available from your benefits administrator. It is also available online at www.eip.sc.gov. Choose your category (Active Subscribers), and then "Publications."

Activation

You must activate your EZ REIMBURSE® Card before you use it for the first time. Just call the toll-free number on the sticker attached to the front of your card, and be sure to sign the back of the card. Once your card is activated, you will be able to use it to pay eligible expenses through your MSA, including:

- Copayments and deductibles for healthcare expenses
- Vision and dental expenses
- Prescription expenses

Using Your Card

You can use the EZ REIMBURSE® Card for eligible medical expenses incurred by you or your eligible dependents. For eligible expenses at your **healthcare providers**, swipe your EZ REIMBURSE® Card as you would with any other debit or credit card. Please remember to keep documentation of your expenses as stated in the IRS regulations.

When you use your EZ REIMBURSE® Card at a participating **pharmacy** for the first time (visit www.fbmc-benefits.com for a list of participating pharmacies), ask the pharmacist

to enter the transaction as a "secondary payer" option. Afterward, whenever you fill a prescription at your pharmacy, your copayment or coinsurance, as well as your expense verification, will be processed automatically.

If you have trouble using your card at your pharmacy, give the instruction sheet, included with your card, to your pharmacist. If you need additional help or information regarding a pharmacy transaction, please contact the Pharmacist Help Desk at **800-361-4542.**

Note: You cannot use your EZ REIMBURSE® Card at online mail-order pharmacies or for over-the-counter expenses, cosmetic dental expenses or eyeglass warranties.

Documentation

You must send in documentation for any EZ REIMBURSE® Card transaction that is *not* a known copayment or prescription expense. Known copayments for your plan are outlined in your *Insurance Benefits Guide*. Acceptable documentation includes an Explanation of Benefits from your insurance plan, a statement or a bill showing:

- Name of the patient
- Name of the service provider
- Date of service
- Type of service and
- Total dollar amount of service

Note: This documentation must be sent to FBMC, using an EZ REIMBURSE® MasterCard® Card Transmittal Sheet, available at www.fbmc-benefits.com, www.eip.sc.gov or from your benefits administrator. The documentation cannot be processed without it.

If you fail to send in the requested documentation for an EZ REIMBURSE® Card expense, your MSA will be subject to:

- *Auto-substitution*, which is the withholding of payment for an eligible manual paper claim to offset any outstanding EZ REIMBURSE® Card transaction
- *Suspension* of your card privileges
- *Reclassification*, which is the reporting of any outstanding card transaction amounts as income on your W-2. If the outstanding expense is reclassified, your card is suspended permanently.

As an FSA participant, you will receive a monthly statement from FBMC. Your statement will include an Outstanding EZ REIMBURSE® Card Transaction section. If a transaction appears in this section, you *must* submit documentation to FBMC for that expense.

Like all other FSA documentation, you must keep your EZ REIMBURSE® Card expense documentation for a minimum of one year, and submit it to FBMC or the IRS upon request.

[1] *The EZ REIMBURSE® MasterCard® Card is issued by MetaBank.*

[2] *There is a $20 annual card fee that is deducted from your account at the start of the year. The card is not available to employees who enroll in a limited-use MSA, which is associated with the Savings Plan and a Health Savings Account.*

You Can Adjust Your Life Insurance Coverage for 2006

Have you considered enrolling in or making changes to your Optional Life or Dependent Life coverage? If so, this is what you can do in October:

Employees:

- Active employees not currently enrolled in the Optional Life Program can enroll for $10,000, $20,000 or $30,000 of Optional Life coverage without providing evidence of insurability.
- Active employees currently enrolled in the Optional Life Program can increase coverage by $10,000, $20,000 or $30,000 without providing evidence of insurability.
- The rules that apply to new hires remain unchanged. For more information, see page 100 of the 2005 *Insurance Benefits Guide* (IBG).

Spouses

- Active employees, who are not currently covering their spouse under Dependent Life, can enroll a spouse for $10,000 or $20,000 of coverage without providing evidence of insurability, whether or not the employees themselves are enrolled in Optional Life coverage.
- Active employees, who are currently covering their spouse under Dependent Life, can increase their spouse's coverage by $10,000 or $20,000 without providing evidence of insurability.
- Coverage of a spouse cannot exceed 50 percent of the employee's coverage, or $100,000, whichever is less. The exception to this is for an employee who is enrolled for $10,000, $20,000 or $30,000. He can enroll his spouse for $10,000 or $20,000.

Please note: Effective January 1, 2006, the suicide exclusion on page 102 of the 2005 IBG will apply to spouses as well as to employees.

Important Reminders:

- Coverage changes become effective January 1, 2006.
- **An employee must be actively at work for any changes to become effective on January 1, 2006. If an employee is absent from work due to an injury or an illness on the date his insurance or his dependent's insurance would otherwise become effective, the effective date of any new or increased insurance coverage will be deferred until the date the employee returns to work as an active, permanent, full-time employee for one full day.**

IRS Extends Current Plan Year for Medical Spending Accounts

The IRS recently released Revenue Notice 2005-42, which enhances your MoneyPlu$ Medical Spending Account (MSA). This notice permits a *grace period* of two months, 15 days. During this grace period, you may use any funds remaining in your MSA for qualified expenses incurred from January 1, 2005 – March 15, 2006.

This means if you have money remaining in your MSA when the 2005 Plan Year ends on December 31, 2005, you may incur eligible expenses and pay these expenses with any unspent funds from your 2005 Plan Year account until March 15, 2006.

The grace period should not be confused with the *run-out period*. This is the period during which you may submit claims for reimbursement of eligible expenses incurred from January 1, 2005 – March 15, 2006. **The run-out period is your proof of loss or claims-filing period, and it ends March 31, 2006.**

If you have any questions regarding IRS Revenue Notice 2005-42 and how it may affect your MoneyPlu$ Medical Spending Account, contact FBMC Customer Service at 800-342-8017 or by e-mail at webcustomerservice@fbmc-benefits.com.

Update Your Beneficiaries During Open Enrollment

If you complete a Notice of Election form (NOE) to make any changes to your insurance coverage during open enrollment, you **must** provide a new list of your Basic Life and Optional Life beneficiaries (if you are covered by these policies).

Even if you are not making changes, this is an excellent opportunity to update the list of those who will receive proceeds from your policies in the event of death. It is particularly important to update this list if there has been a major event in your life, such as a marriage or a divorce. In addition, you may name contingent beneficiaries — those who will receive the proceeds from your policy if the main beneficiaries do not survive you. Beneficiaries may include individuals, trusts or organizations.

In some cases, subscribers need to provide the Employee Insurance Program with additional information about their beneficiaries because files are incomplete. Other subscribers need to change their beneficiaries because those they originally listed have died. Updating your beneficiaries and providing complete information about them will help make things a little easier on your family at a difficult time.

Comparison of Health Plan

Plan	SHP Savings Plan		SHP Standard Plan[3]		BlueChoice HealthPlan of South Carolina[3]
Availability	Coverage worldwide		Coverage worldwide		Available in all South Carolina counties Coverage worldwide
Active Employee Monthly Premiums *Employee Only* *Employee/Spouse* *Employee/Children* *Full Family*	**$ 9.28** **$ 72.56** **$ 20.28** **$108.56**		**$ 93.46** **$237.50** **$142.46** **$294.58**		**$125.30** **$365.72** **$268.46** **$540.18**
	Please note that premiums for optional employer groups, such as local subdivisio				
Annual Deductible *Single* *Family*	**(no per-occurrence deductibles)** **$3,000** **$6,000**		**$350** **$700**		**$250** **$500**
Coinsurance	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	HMO pays 90% after copays You pay 10%
Coinsurance Maximum *Single* *Family*	**$2,000** **$4,000** **(excludes deductible)**	**$4,000** **$8,000** **(excludes deductible)**	**$2,000** **$4,000** **(excludes deductible)**	**$4,000** **$8,000** **(excludes deductible)**	**$1,500** **$3,000** **(excludes deductible)**
Physicians Office Visits	Chiropractic payments limited to **$500** a year, per person No per-occurrence deductible or copayments		**$10** per-occurrence deductible, then:		**$15** PCP copayment **$15** OB/GYN well woman exam **$30** specialist copay
	In-network Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	
Hospitalization/ Emergency Care	No per-occurrence deductibles or copayments		Outpatient hospital: **$75** per-occurrence deductible Emergency care: **$125** per-occurrence deductible		Inpatient: **$200** copay Outpatient: **$75** copay/first 3 visits Emergency care: **$100** copay HMO pays 90% after copays You pay 10% **$35** urgent care copay, then HMO pays 100%
Prescription Drugs	Participating pharmacies and mail order only: You pay the State Health Plan's allowable cost until the annual deductible is met. Afterward, the Plan will reimburse 80% of the allowable cost; you pay 20%. When coinsurance maximum is reached, the Plan will reimburse 100% of the allowable cost.		Participating pharmacies only (up to 31-day supply): **$10** generic, **$25** preferred brand, **$40** non-preferred brand Mail order (up to 90-day supply): **$25** generic, **$62** preferred brand, **$100** non-preferred brand Out-of-pocket max: **$2,500**		Participating pharmacies only (31-day supply): **$8** generic, **$30** preferred brand, **$50** non-preferred brand, **$75** specialty pharmaceuticals Mail order (Up to 90-day supply):**$16** generic, **$60** preferred brand, **$100** non-preferred brand

[1]This table is for comparison purposes only.
[2]There will be no copayment for services performed at MUSC outpatient facilities.
[3]Refer to your 2005 *Insurance Benefits Guide* for information on how this plan coordinates with Medicare.

Benefits Offered for 2006[1]

CIGNA HMO[3]	MUSC Options[3]	Medicare Supplemental Plan[3]
Available in all South Carolina counties, **except**: *Abbeville, Aiken, Barwell, Edgefield, Greenwood, McCormick and Saluda counties*	Available in these South Carolina counties: *Berkeley, Charleston, Colleton and Dorchester counties*	Same as Medicare Available to retirees and covered dependents/survivors who are eligible for Medicare
$127.00 **$365.18** **$267.12** **$536.98**	**$119.24** **$335.38** **$223.56** **$431.82**	Refer to the premium tables on pages 10-11 for rates

ons, may vary. To verify your rates, contact your benefits office.

NONE	**In-network** NONE	**Out-of-network** **$300** **$900**	Pays Medicare Part A and Part B deductibles
HMO pays 80% after copays You pay 20%	HMO pays 100% after copays	HMO pays 60% of allowance You pay 40%	Pays Part B coinsurance of 20%
$3,000 **$6,000** **(includes inpatient, outpatient, copays and coinsurance)**	N/A	**$3,000** **$9,000** **(excludes deductible)**	None
$20 PCP copayment **$40** OB/GYN exam **$40** specialist copay	**$15** PCP copay; **$15** OB/GYN well woman exam; **$25** specialist copay with referral; **$45** specialist copay without referral	HMO pays 60% of allowance after annual deductible You pay 40%. No preventive care benefits out-of-network	Pays Part B coinsurance of 20%
Inpatient: **$500** copay Outpatient facility: **$250** copay Emergency care: **$100** copay	Inpatient: **$300** copay Outpatient facility: **$100**[2] copay Emergency Care: **$100** copay; **$35** urgent care copay	HMO pays 60% of allowance after annual deductible You pay 40% Emergency care: **$100** copay	**For inpatient hospital stays**, the Plan pays: Medicare deductible; coinsurance for days 61-90; coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required) **For skilled nursing care**, the Plan pays coinsurance for days 21-100; 100% beyond 100 days, up to $6,000 or 60 days, whichever is less.
Participating pharmacies only (up to 30-day supply): **$7** generic, **$25** preferred brand, **$50** non-preferred brand Mail order (up to 90-day supply): **$14** generic, **$50** preferred brand, **$100** non-preferred brand	Participating pharmacies only (up to 30-day supply): **$10** generic, **$25** preferred brand, **$40** non-preferred brand Mail order (up to 90-day supply): **$15** generic, **$50** preferred brand, **$80** non-preferred brand		Participating pharmacies only (up to 31-day supply): **$10** generic, **$25** preferred brand, **$40** non-preferred brand Mail order (up to 90-day supply): **$25** generic, **$62** preferred brand, **$100** non-preferred brand; Out-of-pocket max: **$2,500**

MUSC Options Now Open to Medicare Retirees

MUSC Options, a point-of-service health maintenance organization (HMO), will become available on January 1, 2006, to subscribers enrolled in Medicare.

This product, offered in Berkeley, Charleston, Colleton and Dorchester counties, also serves active employees, survivors and COBRA subscribers. Subscribers may switch to MUSC Options during open enrollment, October 1–31.

MUSC Options subscribers select a primary care physician (PCP). For the highest level of benefits, medical services must be authorized in advance by the PCP and/or BlueChoice HealthPlan of SC, the plan administrator. Medco administers MUSC Options' prescription drug program.

MUSC Options will work with Medicare the same way BlueChoice HealthPlan of SC (formerly Companion HMO) works with Medicare. It pays only Medicare-approved charges, and it will pay the Medicare Part A and Medicare Part B deductibles in full. The plan also pays the 20 percent coinsurance when Medicare pays 80 percent of Part B-approved charges. For more information, see "How Companion HMO (now BlueChoice) and Medicare Work Together" on pages 193-194 of the 2005 *Insurance Benefits Guide* (IBG).

For general information about MUSC Options see pages 62-65 of the IBG. For answers to specific questions, call 800-821-3023. The provider directory is available on the Web at www.bluechoicesc.com or by calling the number above.

Other HMO Plan changes for 2006

BlueChoice HealthPlan:

- Specialist copay will increase to $30
- Retail copay will increase to $30 for preferred-brand drugs; $50 for non-preferred brand drugs (copay for generics will remain the same)
- Mail-order copay will increase to $60 for preferred-brand drugs; $100 for non-preferred brand drugs (copay for generics will remain the same)

CIGNA HealthCare:

- No plan changes

2006 Active Employee Monthly Premiums[1]
State Health Plan

	SAVINGS	STANDARD	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Employee	$ 9.28	$ 93.46	$125.30	$127.00	$119.24	$0.00	$ 0.00	$18.52
Employee/spouse	$ 72.56	$237.50	$365.72	$365.18	$335.38	$0.00	$ 7.64	$35.06
Employee/children	$ 20.28	$142.46	$268.46	$267.12	$223.56	$0.00	$13.72	$38.26
Full family	$108.56	$294.58	$540.18	$536.98	$431.82	$0.00	$21.34	$54.80

[1]Rates for employees of local subdivisions may vary. To verify your rates, contact your benefits office.

2006 Regular Retiree (State-funded Benefits) Monthly Premiums[1]

(Retiree eligible for Medicare/spouse eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree	N/A	$ 75.46	$ 93.46	$125.30	$127.00	$119.24	N/A	$ 0.00	$18.52
Retiree/spouse	N/A	$201.50	$237.50	$365.72	$365.18	$335.38	N/A	$ 7.64	$35.06
Retiree/children	N/A	$124.46	$142.46	$268.46	$267.12	$223.56	N/A	$13.72	$38.26
Full family	N/A	$258.58	$294.58	$540.18	$536.98	$431.82	N/A	$21.34	$54.80

(Retiree eligible for Medicare/spouse **not** eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/spouse	N/A	$219.50	$237.50	$365.72	$365.18	$335.38	N/A	$ 7.64	$35.06
Full family	N/A	$268.50	$286.50	$540.18	$536.98	$431.82	N/A	$21.34	$54.80

(Retiree **not** eligible for Medicare/spouse eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/spouse	$ 72.56	$219.50	$237.50	$365.72	$365.18	$335.38	N/A	$ 7.64	$35.06
Full family	$108.56	$268.50	$286.50	$540.18	$536.98	$431.82	N/A	$21.34	$54.80

(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree	$ 9.28	$ 93.46	N/A	$125.30	$127.00	$119.24	$0.00	$ 0.00	$18.52
Retiree/spouse	$ 72.56	$237.50	N/A	$365.72	$365.18	$335.38	$0.00	$ 7.64	$35.06
Retiree/children	$ 20.28	$142.46	N/A	$268.46	$267.12	$223.56	$0.00	$13.72	$38.26
Full family	$108.56	$294.58	N/A	$540.18	$536.98	$431.82	$0.00	$21.34	$54.80

(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare/one or more children eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/children	$ 20.28	$142.46	$160.46	$268.46	$267.12	$223.56	N/A	$13.72	$38.26
Full family	$108.56	$294.58	$312.58	$540.18	$536.98	$431.82	N/A	$21.34	$54.80

[1]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2]If the Medicare Supplemental Plan is elected, claims for covered persons not eligible for Medicare will be based on the Standard Plan provisions.

2006 COBRA Monthly Premiums

18 and 36 months

	SAVINGS	STANDARD	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Subscriber only	$245.94	$331.82	$ 364.28	$ 366.02	$358.10	N/A	$11.94	$18.89
Subscriber/spouse	$536.10	$704.34	$ 835.12	$ 834.56	$804.18	N/A	$19.74	$35.76
Subscriber/children	$354.42	$479.04	$ 607.56	$ 606.20	$561.76	N/A	$25.94	$39.02
Family	$650.32	$840.06	$1,090.56	$1,087.30	$980.04	N/A	$33.71	$55.90
Children (to age 18)	$108.48	$147.24	$ 243.28	$ 240.18	$203.66	N/A	$13.99	$20.14

29 Months (These rates go into effect in the 19th month of coverage for 29-month COBRA subscribers)

	SAVINGS	STANDARD	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Subscriber only	$361.68	$ 487.96	$ 535.72	$ 538.26	$ 526.62	N/A	$11.94	$18.89
Subscriber/spouse	$788.38	$1,035.78	$1,228.12	$1,227.30	$1,182.60	N/A	$19.74	$35.76
Subscriber/children	$521.20	$ 704.46	$ 893.46	$ 891.46	$ 826.12	N/A	$25.94	$39.02
Family	$956.34	$1,235.38	$1,603.78	$1,598.98	$1,441.24	N/A	$33.71	$55.90
Children (to age 18)	$159.52	$ 216.50	$ 357.74	$ 353.20	$ 299.50	N/A	$13.99	$20.14

2006 Retiree Full Cost (Non-funded) Monthly Premiums[1]

(Retiree eligible for Medicare/spouse eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree	N/A	$307.30	$325.30	$ 357.14	$ 358.82	$351.06	N/A	$11.71	$18.52
Retiree/spouse	N/A	$654.52	$690.52	$ 818.74	$ 818.20	$788.40	N/A	$19.35	$35.06
Retiree/children	N/A	$451.64	$469.64	$ 595.62	$ 594.30	$550.72	N/A	$25.43	$38.26
Full family	N/A	$787.58	$823.58	$1,069.18	$1,065.98	$960.82	N/A	$33.05	$54.80

(Retiree eligible for Medicare/spouse **not** eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/spouse	N/A	$672.52	$690.52	$ 818.74	$ 818.20	$788.40	N/A	$19.35	$35.06
Full family	N/A	$797.50	$815.50	$1,065.98	$1,065.98	$960.82	N/A	$33.05	$54.80

(Retiree **not** entitled to Medicare/spouse entitled to Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/spouse	$525.58	$672.52	$690.52	$ 818.74	$ 818.20	$788.40	N/A	$19.35	$35.06
Full family	$637.56	$797.50	$815.50	$1,069.18	$1,069.18	$960.82	N/A	$33.05	$54.80

(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree	$241.12	$325.30	N/A	$ 357.14	$ 358.82	$351.06	$ 63.50	$11.71	$18.52
Retiree/spouse	$525.58	$690.52	N/A	$ 818.74	$ 818.20	$788.40	$122.50	$19.35	$35.06
Retiree/children	$347.46	$469.64	N/A	$ 595.62	$ 594.30	$550.72	$122.50	$25.43	$38.26
Full family	$637.56	$823.58	N/A	$1,069.18	$1,065.98	$960.82	$163.50	$33.05	$54.80

(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare/one or more children eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[2]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Retiree/children	$347.46	$469.64	$487.64	$ 595.62	$ 594.30	$550.72	N/A	$25.43	$38.26
Full family	$637.56	$823.58	$841.58	$1,069.18	$1,065.98	$960.82	N/A	$33.05	$54.80

[1]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2]If the Medicare Supplemental Plan is elected, claims for covered persons not entitled to Medicare will be based on the Standard Plan provisions.

2006 Survivor Monthly Premiums[1]

(Spouse eligible for Medicare/children eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[3]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Spouse	N/A	$307.30	$325.30	$357.14	$358.82	$351.06	N/A	$11.71	$18.52
Spouse/children	N/A	$451.64	$487.64	$595.62	$594.30	$550.72	N/A	$25.43	$38.26
Children only	N/A	$144.34	$162.34	$238.48	$235.48	$199.66	N/A	$13.72	$19.74

(Spouse eligible for Medicare/children **not** eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[3]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Spouse	N/A	$307.30	$325.30	$357.14	$358.82	$351.06	N/A	$11.71	$18.52
Spouse/children	N/A	$451.64	$469.64	$595.62	$594.30	$550.72	N/A	$25.43	$38.26
Children only	$106.34	$144.34	N/A	$238.48	$235.48	$199.66	N/A	$13.72	$19.74

(Spouse **not** eligible for Medicare/children eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[3]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Spouse	$241.12	$325.30	N/A	$357.14	$358.82	$351.06	N/A	$11.71	$18.52
Spouse/children	$347.46	$469.64	$487.64	$595.62	$594.30	$550.72	N/A	$25.43	$38.26
Children only	N/A	$144.34	$162.34[4]	$238.48	$235.48	$199.66	N/A	$13.72	$19.74

(Spouse **not** eligible for Medicare/children **not** eligible for Medicare)

	SAVINGS	STANDARD	SUPPLEMENTAL[3]	BlueChoice HealthPlan	CIGNA	MUSC OPTIONS	TRICARE	DENTAL	DENTAL PLUS
Spouse	$241.12	$325.30	N/A	$357.14	$358.82	$351.06	$ 63.50	$11.71	$18.52
Spouse/children	$347.46	$469.64	N/A	$595.62	$594.30	$550.72	$122.50	$25.43	$38.26
Children only	$106.34	$144.34	N/A	$238.48	$235.48	$199.66	$ 63.50	$13.72	$19.74

[1]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2]Plan premiums for spouses and dependents will be waived for one year after the death of the funded employee or retiree for those covered as dependents under the Plan at the time of death.
[3]If the Medicare Supplemental Plan is elected, claims for covered subscribers not eligible for Medicare will be based on the Standard Plan provisions.
[4]This premium applies only if one or more children are eligible for Medicare.

Attention Medicare Enrollees:

Subscribers Who Enroll in Medicare Part D Lose EIP Drug Coverage

Medicare Part D, Medicare's new prescription drug plan, will become effective January 1, 2006. However, most subscribers covered by the State Health Plan Standard Plan, by the Medicare Supplemental Plan or by the health maintenance organizations offered through the Employee Insurance Program (EIP) should not sign up for Medicare Part D. Because the State Plan will maintain drug coverage at least as good as that provided by Part D, Medicare will provide subsidies to the state that will help fund the Plan.

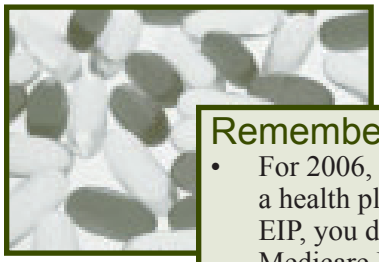
The prescription drug benefit you already have through your health plan is as good as, or better than, what is offered under Part D. Because you have this coverage, your drug expenses will continue to be reimbursed through the health plan you have through EIP. This fall, you will receive a letter from EIP officially notifying you that your coverage is at least as generous as Part D and therefore you do not need to sign up for Part D.

Your prescription drug coverage under your state insurance is superior to Part D. **If you enroll in Medicare Part D, you will lose the prescription drug coverage provided by your health plan with EIP, and the premium for your health plan will not be reduced.**

By October, you should receive the *Medicare and You 2006* handbook from the Centers for Medicare and Medicaid Services (Medicare). Anyone covered by Medicare may sign up for Part D. However, there are costs, which vary according to which of the several Part D plans you choose. The federal government estimates a benefit will cost:

- A monthly premium of $32 (in addition to any premiums for Part A and Part B)
- A $250 annual deductible
- After a $250 annual deductible, coinsurance vary from 25 percent to 100 percent to 5 percent depending on how much you have paid for prescription drugs during the year.

You may have heard that if you do not sign up for Medicare Part D by May 15, 2006, and then later decide to do so, you will have to pay higher premiums for Part D. For EIP subscribers, this is not true. According to Medicare rules, Medicare recipients who have "creditable coverage," (prescription drug coverage that is as good as, or better than, Part D) and who later decide to sign up for Part D will not have to pay a penalty in the form of higher Part D premiums. Subscribers to the health plans offered through EIP have this kind of coverage. However, it is very important for you to save the Notice of Creditable Coverage letter you receive from EIP in case you need to prove you had this coverage when Medicare Part D began.



If you receive information from Medicare or advertisements from companies asking you to buy Part D prescription drug plans, no action is necessary .

There is an exception:

If you are covered by Medicare, you may be eligible for higher benefits under Part D if your monthly income is less than $1,196.25 for individuals and less than $1,603.75 for married couples, and you have limited savings and investments. Part D could lower your out-of-pocket drug costs. If you feel you may qualify for additional assistance, contact Medicare at the telephone number below.

Please remember:

Medicare Part D does not affect your need to enroll in both Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) when you become eligible for Medicare. As a retiree under our insurance program, you must enroll in Part A and Part B when you become eligible for Medicare if you are no longer an active employee and are retired either due to a disability or due to age. Even if you are **not** enrolled in both parts of Medicare, EIP's group plans will pay benefits as if you are.

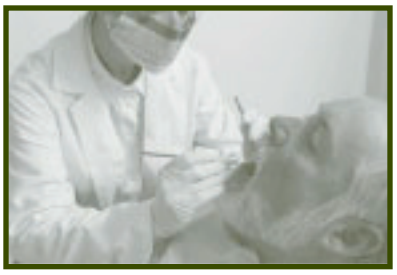
If you have questions about your drug coverage through EIP, please call EIP at 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

You can contact Medicare at 800-MEDICARE (800-633-4227) or at 877-486-2048 (TTY), for the hearing impaired. Information is also available on Medicare's Web site, www.medicare.gov.

Remember:

- For 2006, if you are covered by a health plan offered through EIP, you do not need to enroll in Medicare Part D. You will lose your prescription drug coverage through EIP if you do.
- No action is needed when you receive information about Medicare Part D – unless you may qualify for the increased benefit for lower-income Medicare recipients.
- You do not need to take any action to continue coverage offered through EIP.
- Prescription drug coverage offered through EIP is as good as, or better than, Medicare Part D coverage.
- Medicare recipients who sign up for Part D will pay a monthly premium, prescription coinsurance and an annual deductible. You will lose your drug coverage through EIP health plans, and there will be no reduction in your health insurance premium.

Dental Plus: A Good Value



During this open-enrollment period, you may want to consider enrolling in the Dental Plus Plan. All employees enrolled in health insurance through the Employee Insurance Program have State Dental Plan coverage, for which they pay no premiums. Although Dental Plus subscribers pay a monthly premium, Dental Plus offers substantial savings should you need exams and cleanings as well as services beyond basic prevention. Consult the following tables to decide if Dental Plus is right for you. You may feel the actual expense for this added coverage is quite modest when compared to the added insurance protection.

	Employee only	Employee and spouse	Employee and Child(ren)	Full Family
Dental Plus monthly premium	$18.52	$35.06	$38.26	$54.80
Yearly total of monthly premium payments	$222.24 ($18.52 x 12)	$420.72 ($35.06 x 12)	$459.12 ($38.26 x 12)	$657.60 ($54.80 x 12)
Estimated amount saved per year if you use MoneyPlu$ to pay your premiums pretax (estimated at 30% of the premium payment)	$66.67 (30% of $222.24)	$126.22 (30% of $420.72)	$137.74 (30% of $459.12)	$197.28 (30% of $657.60)
Estimated net annual Dental Plus premium	$155.57 ($222.24 - $66.67)	$294.50 ($420.72 - $126.22)	$321.38 ($459.12 - $137.74)	$460.32 ($657.60 - $197.28)
Amount Dental Plus pays beyond what State Dental Plan pays for Dental exams, cleanings, and X-rays (2 times a year)	$80.00	$160.00	$240.00	$320.00
Estimated annual net cost of Dental Plus coverage if you use only basic services	$75.57 ($155.57 - $80.00) $6.30/month ($75.57 ÷ 12)	$134.50 ($294.50 - $160.00) $11.21/month ($134.50 ÷ 12)	$81.38 ($321.38 - $240) $6.78/month ($81.38 ÷ 12)	$140.32 ($460.32 - $320) $11.69/month ($140.32 ÷ 12)

Dental Plus has a higher allowable fee for a service than the State Dental Plan. Consequently, Dental Plus saves you a substantial amount when compared to the State Dental Plan should you or an enrolled family member need an emergency or restorative dental procedure. Below is an example of how Dental Plus covers a common restorative procedure and the amount of savings involved. Should you need more than one of these services in a year, your amount of savings really adds up.

Example	**Crown** (resin with predominant base metal)
Dentist's charge*	$680.00
State Dental Plan coverage	Plan pays 50%
State Dental Plan allowable	$349.00
State Dental Plan pays	$174.50 (50% of $349.00)
Out-of-pocket expense with ***State Dental Plan alone***	**$505.50**
Dental Plus allowable	**$686.00**
Dental Plus pays (50% of the dentist's charge or 50% of the allowable charge, whichever is less)	**$340.00** (50% of $680.00)
With Dental Plus you pay this amount out-of-pocket	**$340.00** ($680.00 - $340.00)
Savings with Dental Plus	**$165.50** ($505.50 - $340.00)

**Your dentist's charges may vary, and your tax savings with MoneyPlu$ may be more. Your savings are even greater if you use a MoneyPlu$ Medical Spending Account to set aside your estimated out-of-pocket deductible and coinsurance amounts on a pre-tax basis.*

More Choices, More Options, More Savings

With all the plans the Employee Insurance Program offers, how do you know which type of plan is right for you? Although needs and preferences differ from one subscriber to another, we hope this table is helpful as you sort through your options for 2006. Be sure to review the comparison chart on pages 8 and 9 for more details and availability.

	Preferred Provider Organization	Traditional HMO	HMO with Point-of-Service option	High Deductible Health Plan with Health Savings Account
What is it?	A health plan that provides greater benefits when using a provider in its network of providers. However, it allows the subscriber to receive care outside the network for lesser coverage.	A health plan that may not allow coverage outside its network of providers or service area (except in emergencies.) Care is approved by the HMO and directed through a primary care physician, who handles referrals.	Similar in concept to an HMO, in that care is directed through a primary care physician and approved by the HMO. However, it allows the subscriber to receive care outside of the network for lesser coverage.	A low-cost health plan that encourages healthy lifestyles and thrift. Participants have full coverage and higher deductibles. They may choose to increase their savings by using network providers and generic or preferred brand drugs.
For whom is it designed?	A PPO is designed for individuals and families who want to make more of their own healthcare choices, but still want some coverage for routine medical expenses. Those with covered family members living or traveling out of state may find the provider networks and out-of-network benefits, which are characteristic of a PPO, helpful.	A traditional HMO is designed for those who want help managing their routine medical expenses, in addition to coverage for major healthcare expenses.	An HMO with a point-of-service (POS) option is designed for those who want help managing routine medical expenses, but also want the freedom to use a provider not in the HMO's network.	An HDHP plan is designed for those who are willing to pay higher deductibles and take more responsibility for their routine medical expenses, in exchange for lower premiums and an optional tax-free Health Savings Account (HSA) that can help pay these expenses.
Which EIP plan offers this type of coverage?	SHP Standard Plan	CIGNA HMO,BlueChoice HealthPlan HMO (See pages 8-9 for information on availability)	MUSC Options (See pages 8-9 for information on availability)	SHP Savings Plan

Subscribers Can Allow EIP to Share Health Information

Your right to keep your health information private is important – and is protected by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This law is a very serious matter. Unless you are the policyholder, or you have a signed Authorized Representative Form on file, EIP Customer Services Representatives will provide only the information that pertains to you and only the information necessary to fulfill your request.

If you **are not** the policyholder, personal health information will not be disclosed unless there is an Authorized Representative Form on file that gives you the authority to receive the information or if you are the legal parent/guardian for a covered minor.

Without a signed authorization form, benefits administrators who call on behalf of an employee will be able to receive only the information needed to determine coverage/premium amounts and to properly complete enrollment forms.

Anyone enrolled in a health plan offered through EIP may fill out an Authorized Representative Form, which gives EIP permission to release your personal health information to specific individuals. If you wish, you may limit the kind of information that will be released to your authorized representative. This authorization can be revoked at any time.

Another document that allows EIP to discuss your personal health information with a designated representative of your choice is the health care power of attorney. A health care power of attorney grants to the person named as an individual's agent the power to make health care decisions on behalf of that individual if he or she cannot make those decisions. The health care power of attorney is a legal document that you should discuss with your attorney.

Unlike a health care power of attorney, the Authorized Representative Form does not give the authorized representative any authority over any treatment or direct-care decisions.

The Authorized Representative Form and a Notice of Privacy Practices, which discusses HIPAA, are available on the EIP Web site, www.eip.sc.gov. Choose your category, select "Forms" and then click on "HIPAA Information." You can also obtain a copy of the form by calling EIP at 803-734-0678 in the Columbia area and 888-260-9430 outside the Columbia area. The notice is also included in the 2005 *Insurance Benefits Guide,* beginning on page 233.

Important Contact Information for Open Enrollment

AETNA Long Term Care

- Customer Service Phone: 800-537-8521
- Fax: 860-952-2024
- Web: www.aetna.com/group/southcarolina

APS Healthcare Inc. – State Mental Health and Substance Abuse

- Customer Service Phone: 800-221-8699
- Tobacco Treatment: 866-784-8454
- Fax: 888-897-8931
- Web: www.apshealthcare.com (password: statesc)

ASI – TRICARE Supplement Plan

- Customer Service Phone: 800-638-2610, ext. 255
- Fax: 301-816-1125
- Web: www.corporatetricare-supp.com, www.tricare.osd.mil

BlueCross BlueShield Of South Carolina

- Health - Customer Service Phone: 803-736-1576 (Greater Columbia area) 800-868-2520 (toll-free outside Columbia area)
- Health Fax: 803-699-7675
- Medi-Call: 803-699-3337 (Greater Columbia area) 800-925-9724 (toll-free outside Columbia area)
- Medi-Call Fax: 803-264-0183
- BlueCard Program Phone: 800-810-BLUE (2583)
- Dental - Customer Service Phone: 888-214-6230
- Dental Fax: 803-264-7739
- Web: www.southcarolinablues.com

CIGNA Healthcare HMO

- Member Services Phone: 800-244-6224
- Web: www.cigna.com

BlueChoice HealthPlan HMO

- Member Services Phone: 803-786-8476 (Greater Columbia area)
- 800-868-2528 (toll-free outside Columbia area)
- Web: www.BlueChoiceSC.com

Fringe Benefits Management Company – MoneyPlu$

- Customer Service Phone: 800-342-8017
- Claims Fax: 850-425-4608
- Other Fax: 850-425-6220
- Web: www.fbmc-benefits.com

The Hartford

- Evidence of Insurability Phone: 800-331-7234
- Death Claims Phone: 888-563-1124
- Retiree Enrollment/Claims Phone: 888-803-7346, ext. 3648
- Insurance Conversion Phone: 800-548-5157

Medco Health

- Customer Service Phone: 800-711-3450
- Web: www.medco.com

MUSC Options

- Member Services Phone: 800-821-3023
- Web: www.BlueChoiceSC.com

The Standard Insurance Company

- Customer Service Phone: 800-628-9696
- Fax: 800-437-0961
- Medical Evidence Phone: 800-843-7979
- Web: www.standard.com

Supplemental Long Term Disability Open Enrollment

Continued from page 1

Medical evidence of good health is not required during this special open enrollment period. Now is the time to take advantage of this opportunity, as an open enrollment will not be offered next year.

Current SLTD Participants

During the open enrollment period, current subscribers who have a 180-day benefit waiting period may **change to a 90-day waiting period without submitting medical evidence of good health**.

Get More Information

If you have questions about the SLTD coverage available to you, refer to your 2005 *Insurance Benefits Guide* (SLTD information begins on p. 128), talk to your benefits administrator or contact the Standard Insurance Company at 800-231-0065 or nbearden@standard.com. For information about how to enroll, contact your benefits administrator or the Employee Insurance Program at 803-734-0678 (Greater Columbia area), at 888-260-9430 (toll-free outside the Columbia area) or at cs@eip.sc.gov.

Steps To Calculate Your SLTD Monthly Premium

1. Always select floating decimal (F) on your calculator.
2. Divide your gross annual salary by 12 to determine monthly salary.
3. Multiply monthly salary by rate factor from the table below.
4. Drop digits to the right of 2 decimal places; do not round.
5. If the number is even, this is the monthly premium.
6. If the number is odd, add .01; this is the monthly premium.

Supplemental Long Term Disability Rate Factors

Age, as of the preceding January 1	90-day waiting period	180-day waiting period
Under 31	0.00065	0.00050
31-40	0.00089	0.00069
41-50	0.00179	0.00137
51-60	0.00360	0.00277
61-65	0.00433	0.00333
Over 65	0.00528	0.00406

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